ORAL HEALTH AMERICA

50 Years of Advocacy

August 15, 2005

Ms. Dorcas R. Hardy
Chairman, Policy Committee
White House Conference on Aging
4350 East West Highway
3rd Floor
Bethesda, MD 20814

Dear Ms. Hardy:

I enclose a Resolution on Oral Health for Older Americans submitted by Oral Health America for review by the White House Conference on Aging.

The sponsor of the Resolution, Oral Health America, is the nation's oldest and only independent foundation advocating for oral health and its relationship to overall health. (Visit our website at http://oralhealthamerica.org/).

The Resolution is the work of noted experts in the field of oral health for older adults, many of whom contributed to the enclosed, "A State of Decay", which provides a state by state analysis of the burden of oral disease borne by America's elderly.

If you have any questions about the Resolution or the work of Oral Health America, please do not hesitate to call.

On behalf of millions of older Americans whose oral and overall health is severely compromised by oral diseases, we thank you for your consideration of this Resolution.

Yours,

Robert J. Klaus
President & CEO

cc: Steve Knight, Chairman, OHA

410 North Michigan Avenue · Suite 352 · Chicago, Illinois 60611-4211 · 312-836-9900 · fax: 312-836-9986

Overview of Current Issue Status and Policy: Good oral health should begin at birth as an important component of overall health care and should not end at retirement. Proper dental care must be a lifetime commitment and must never be considered less of a priority than other health needs. Unfortunately, for far too many older Americans, oral health care is a luxury. Too many suffer from chronic oral pain and disease, severely limiting regular activities of daily living and impending their independence. Evidence suggests that poor oral health can complicate or is linked to diabetes, heart disease, pneumonia and stroke, resulting in the deterioration of overall physical health. Indeed, due to a lack of social marketing targeted toward older adults, few are aware of the important connection of their oral health to their total health.

Opportunities: Limited access to oral health care poses one of the greatest crises for the health and well being of America's elderly. Not one older American receives routine dental care under Medicare and less than 20% of those over 75 years have any form of private dental insurance. The likelihood of serious dental problems coupled with limited access becomes more serious for those older Americans with special needs, are medically compromised, disabled, blind or institutionalized. The 2002 Surgeon General's National Call to Action to Promote Oral Health recognizes the value of changing the public's perception of the importance of oral health to overall physical health and calls for raising the level of awareness among policymakers to the need to include oral health in health policies. Concurrently, the public's oral health literacy level must be raised to enable people to make informed decisions and express their needs and expectations to their health care providers and elected officials.

Resolution:

Support an oral health literacy campaign for older adults that has the following objectives:

- Alerting older Americans to the importance of oral health and its fundamental relationship to overall health.

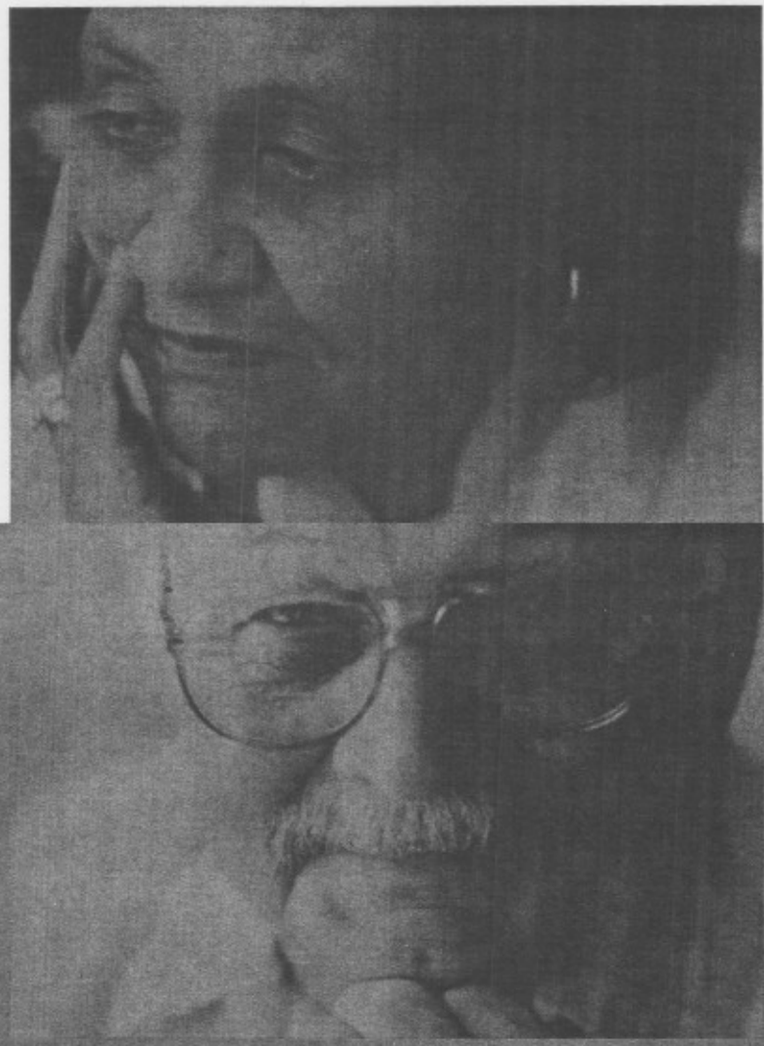
- Raising awareness among opinion leaders, health care providers, elected officials and the media that poor oral health is one of the leading causes of health problems in older adults, a problem that, for lack of awareness and prevention, wastes tens of millions of dollars annually and causes untold human suffering.

- Raising the oral health literacy of all adult Americans.

Submitted by Oral Health America to the Policy Committee of the White House Conference on Aging. August 16, 2005

A State of Decay

THE ORAL HEALTH OF OLDER AMERICANS



AN ORAL HEALTH AMERICA SPECIAL GRADING PROJECT

SEPTEMBER 2003

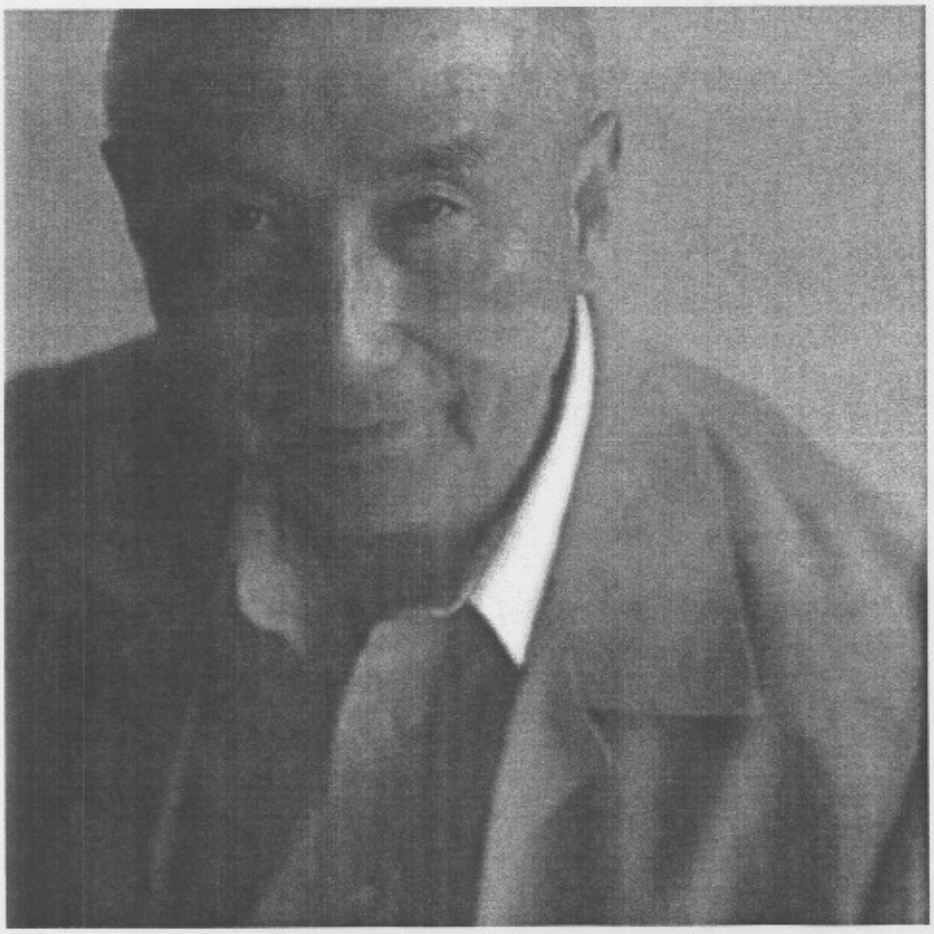
NATIONAL GRADE: D

ORAL HEALTH AMERICA

Campaign for Oral Health Parity

Funded in part by the W.K. Kellogg Foundation

Table of Contents



A State of Decay: The Oral

Poor oral health causes suffering.

Millions of Americans, especially our most vulnerable populations, are unable to access any care and suffer from a "silent epidemic" of oral diseases.[5]

Good oral health care should begin at birth as part of overall health care. This important component of health care should not—and cannot—end at retirement. Proper dental care must be a lifetime commitment. Unfortunately, for far too many older Americans, oral health care is a luxury. Too many of our "greatest generation" suffer from chronic oral pain and periodontal disease, severely limiting regular activities of daily living and impeding their independence. Neglect of oral health may result in the deterioration of overall physical health. Lack of access to care for even routine dental cleanings and exams can exacerbate serious and complicated overall health problems that increase with age.

Limited access to oral health care poses one of the greatest crises for the health and well being of America's elderly. The result is an embarrassing "D." Not one older American receives routine dental care under Medicare. Medigap, used by some older Americans as a supplemental insurance to Medicare, is an expensive cavity when it comes to dental coverage. Less than 20 percent of Americans 75 and older have any form of private dental insurance.[1] Under Medicaid, adult dental care is optional and 27 states are failing to meet even the most minimal standards of care. Millions suffer, often in silence.

A State of Decay	
D	OVERALL GRADE
D	Private Dental Coverage
D+	Level of Adult Medicaid Dental Coverage
F	Adult Medicaid Service Reimbursement Rates
D–	Adult Dental Medicaid Grade Overall

Older adults suffer from the cumulative toll of oral diseases over their lifetime. This results in extensive oral disease.[2] Surveys have shown that nursing home residents with teeth suffer particularly from untreated tooth decay, while those without teeth also have a variety of oral health problems.[3] Medications often adversely affect oral health as well.

Some older Americans—especially those with special needs, the frail, and those classified by the Social Security Administration to be aged, blind and disabled—are often plagued with challenging oral health needs. Being disabled, medically compromised, homebound, or institutionalized increases the likelihood of serious dental problems and limited access to dental care. Our national grade may be a "D" for older Americans overall, but when it comes to caring for vulnerable populations; the country is flat out failing.

This lack of access to oral health care is compounded by a shortage of skilled geriatric dental care professionals, part of a larger national shortage of geriatricians described to the U.S. Senate Special Committee on Aging by the Alliance for Aging Research in their report, *Medical Never-Never Land*. Just finding a dentist can pose a considerable challenge for older Americans and those with a disability. The good work of community health centers is limited to providing preventative and basic dental care to only about one-in-twelve patients who are fortunate enough to have access to such a facility.[4] In many states that provide a dental benefit, reimbursement rates are too low to attract a sufficient number of dentists willing to treat Medicaid patients.

[1] Centers for Disease Control and Prevention (CDC). Surveillance for Use of Preventive Health Care Services by Older Adults, 1995-1997. *Morbidity and Mortality Weekly Report*. December 17, 1999. 48(SS08):51-88.

[2] Beck JD, Hunt RJ. "Oral health status in the United States: problems of special patients." *J Dent Educ* 1985; 49(6): 407-25.

[3] Bonito, AJ. "Executive Summary: dental care considerations for vulnerable populations." *Special Care in Dentistry* 2002; 22(3): 5S-10S.

[4] U.S. Department of Health and Human Services (DHHS). "Oral Health in America: A Report of the Surgeon General." Rockville, MD: National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

[5] DHHS, "Oral Health in America."

Health of Older Americans

ABOUT THIS REPORT CARD

In 2000, Oral Health America issued the first national report card on oral health. Two subsequent national scoring efforts showed a disturbing trend. The oral health of older Americans was receiving some of the lowest grades across the nation. While in other areas of overall health care access there tends to be variation by state, older Americans almost universally lack private or government dental coverage. This report provides a first ever, state-by-state assessment of the oral health of older Americans, especially those most in need.

Further, *A State of Decay* examines access to oral health for older Americans and reviews adult Medicaid dental coverage in all 50 states and the District of Columbia. As many severe dental problems accumulate over time, looking at dental coverage in the adult Medicaid population provides as accurate a measure as possible of the oral health of our most vulnerable older Americans and special care populations.

ABOUT THE GRADES

Starting with the baseline grade of how many older Americans have private dental insurance—the number one factor in determining if someone sees a dentist—there is grave concern of what happens to the vast majority of older Americans who have no such coverage. With no Medicare dental coverage, many older Americans must rely on Medicaid for critical oral health services. Oral Health America conducted a survey of all 50 states in August 2003 to determine levels of adult dental Medicaid coverage, and assess rates at which Medicaid dental providers are being reimbursed for basic oral health procedures. These grades are not intended to target state programs, but instead, provide a snapshot of how the Medicaid population is faring when it comes to access to needed oral health services.

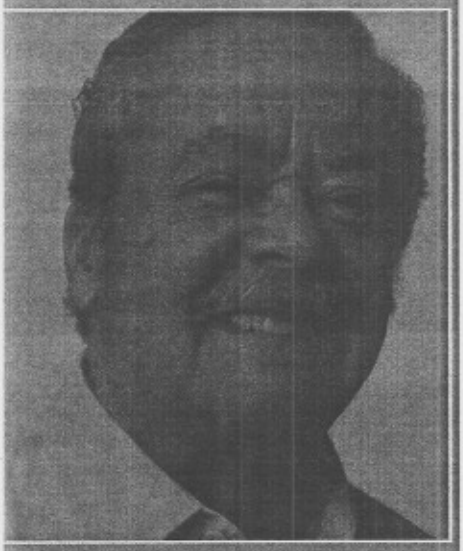
State programs face considerable challenges with current budget shortfalls. Given that oral health services have been considered less of a priority than other health needs, they often get cut first. Particularly at risk as a result of these cuts are our most vulnerable aged, blind and disabled populations, which are dependent on Medicaid as an important source of health care.

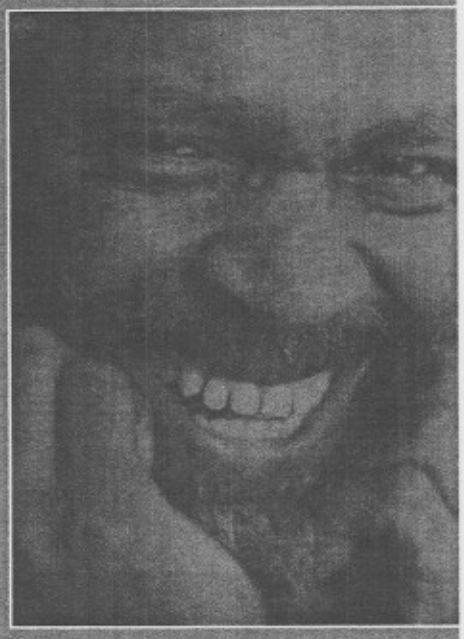
NATIONAL AVERAGES

The final grade for the nation, a "D," illustrates many gaps in oral health coverage and access for older Americans. This grade examines national access to private dental insurance coverage; the level of adult dental Medicaid coverage, and service measures for states providing coverage to older adults. While a variety of measures and grading scales could be employed to moderately improve or reduce this national grade for access to oral health for older Americans, the fact is clear: across the nation, the oral health of older Americans is in a state of decay. What is perhaps most disappointing about this grade is that America should be receiving nothing short of a solid "A" in providing for the oral health of older Americans.

Private dental coverage for older Americans is a "D." This grade examines only who has coverage. Not enough information is available to grade the quality of private

Oral health problems cause pain, impact our ability to eat, sleep, work, and remain independent. Evidence suggests that poor oral health can complicate or is linked to diabetes, heart disease, pneumonia, and stroke.





Oral health ailments—cavities, cancer, gum disease, tooth loss, oral-craniofacial injuries and birth defects—afflict more Americans than any other cluster of health problems.

dental coverage. A total of 16 states fail by having less than 20 percent of their older citizens covered through private dental insurance. Not knowing what type of coverage is included in those policies may mask an even larger problem.

The grade for the level of adult Medicaid dental coverage is a "D+," highlighting the fact that most states (20) provide emergency services—allowing for tooth extractions or oral surgery when the patient is in a life-threatening or emergency situation. Only 10 states providing full or comprehensive dental benefits to Medicaid-eligible adults, earning them "A" and "B" grades. Six states fail outright, offering no adult dental Medicaid benefits.

Across the board, state Medicaid programs reimburse dentists for basic services at rates that are overwhelmingly below customary fees. Many states require pre-authorization for dental procedures, even under emergency conditions, providing yet another barrier to treatment. The national average for adult Medicaid dental service reimbursement rates is an "F." Tennessee earned the highest grade for this category, with only a "C-."

The combination of these two scores, F and D+, earns the nation a dismal "D-" grade for overall adult dental Medicaid coverage. Other than New York with a "B-," no state earned above a "C," and five states earned that lackluster grade: California, Indiana, New Mexico, North Dakota, and Washington.

GRADING SCALES

The following scale was used to assign point values for letter grades. An "I" represents "incomplete," where information was not available.

A	4.00
B+	3.33-3.99
B	3.00-3.32
B-	2.67-2.99
C+	2.33-2.66
C	2.00-2.32
C-	1.67-1.99
D+	1.33-1.66
D	1.00-1.32
D-	0.67-0.99
F	0.00-0.66
I	Information not available.

A. Private Dental Insurance for Older Americans

Older adults often have special oral health needs. As there are no dental benefits under Medicare, older Americans without private dental insurance have no means of accessing care unless they are able to pay out-of-pocket. This is difficult or impossible for millions of older Americans who suffer from poor oral health. Grades are based on the percentage of adults in the state, 65 years and older, who reported having no dental insurance.

Older Adults Without Private Dental Insurance Grading Scale	
A	0-50%
B	51-60%
C	61-70%
D	71-80%
F	81-100%

Source: Table 15. *MMWR* December 17, 1999, Surveillance for Use of Preventive Health-Care Services by Older Adults, 1995-1997, Centers for Disease Control and Prevention

B. State Adult Medicaid Dental Benefit Coverage

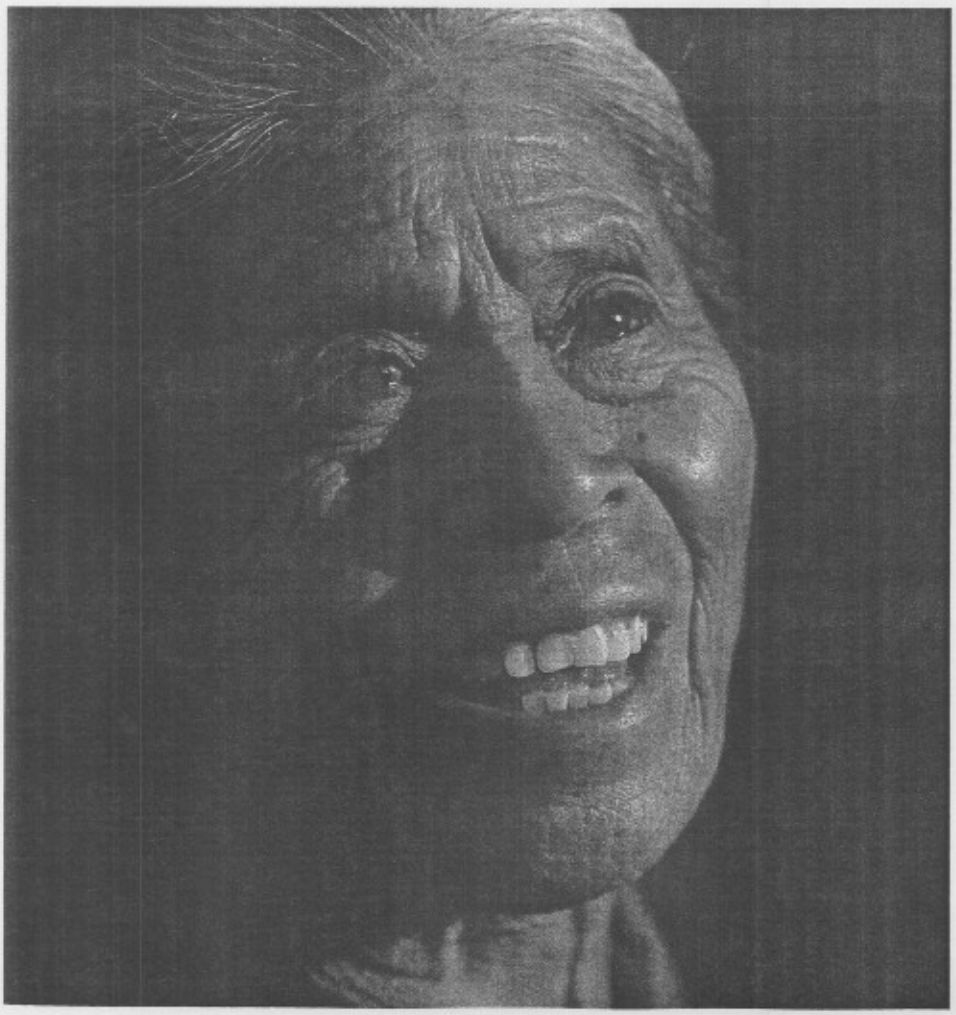
For this category, Oral Health America surveyed states to determine the level of adult dental coverage under Medicaid. States were asked to categorize coverage as "full," "limited," "emergency-only," or "none." Some states indicated that coverage was less than "full," but not "limited," allowing for the "B" grade. This survey updates data collected by Oral Health America in Spring 2003, prior to state legislative sessions, which saw renewed cuts to Medicaid dental benefits.

Grades are based on the level of oral health services provided through the Medicaid program.

State Adult Medicaid Dental Benefit Coverage Grading Scale

A	State provides full dental benefits under Medicaid to the eligible adult population.
B	State dental benefits under Medicaid are considered "comprehensive" but not full for the eligible adult population.
C	Medicaid dental benefits in the state are limited for the eligible adult population.
D	State provides emergency-only dental benefits for adults under Medicaid.
F	State provides no adult dental benefits under Medicaid.

Sources: Oral Health America survey of state dental Medicaid contacts and state Medicaid web sites, August 2003; Oral Health America survey of state dental directors, January 2003; Schneider D, Schneider, K. "Medicaid Dental Care for Adults: A Vanishing Act?" National Oral Health Conference, April 28, 2003 (revised May 2, 2003).



Less than two out of every ten older Americans are covered by private dental insurance.

Poor elderly have a higher percentage of untreated decayed teeth. Members of racial and ethnic groups experience a higher level of oral health problems.

Twenty-three percent of 65- to 74-year olds have severe periodontal disease. People at the lowest socioeconomic levels have more severe periodontal disease.[6]

[6] DHHS, "Oral Health in America."

People with disabilities are at greater risk for oral diseases and are less likely to be treated. One of two persons with a significant disability cannot find a professional resource to provide appropriate and necessary dental care.[7]

Five percent of Americans 65 and older (about 1.65 million people) live in long-term care facilities, where dental care is problematic.[8]

Oral and pharyngeal cancers are diagnosed in about 30,000 Americans annually; 8,000 die from these diseases each year, which are primarily diagnosed in the elderly. Prognosis is poor.[9]

[7] Fenton SJ. "Universal Access: Are We Ready?" [editorial]. *Special Care Dentistry* 1993; 13:94.

[8] DHHS, "Oral Health in America."

[9] DHHS, "Oral Health in America."

[10] Department of Health and Human Services (DHHS). Health Care Financing Administration. Dear State Medicaid Director letter, January 18, 2001. SMDL #01-010.

C. Adult Medicaid Dental Service Reimbursement

Also as part of the survey, Oral Health America asked states to provide information on five basic oral health procedures frequently performed in routine care of Medicaid population patients. These vital procedures include a periodic oral exam, adult teeth cleaning (prophylaxis), periodontal scaling and root planning, upper denture, and a single tooth extraction.

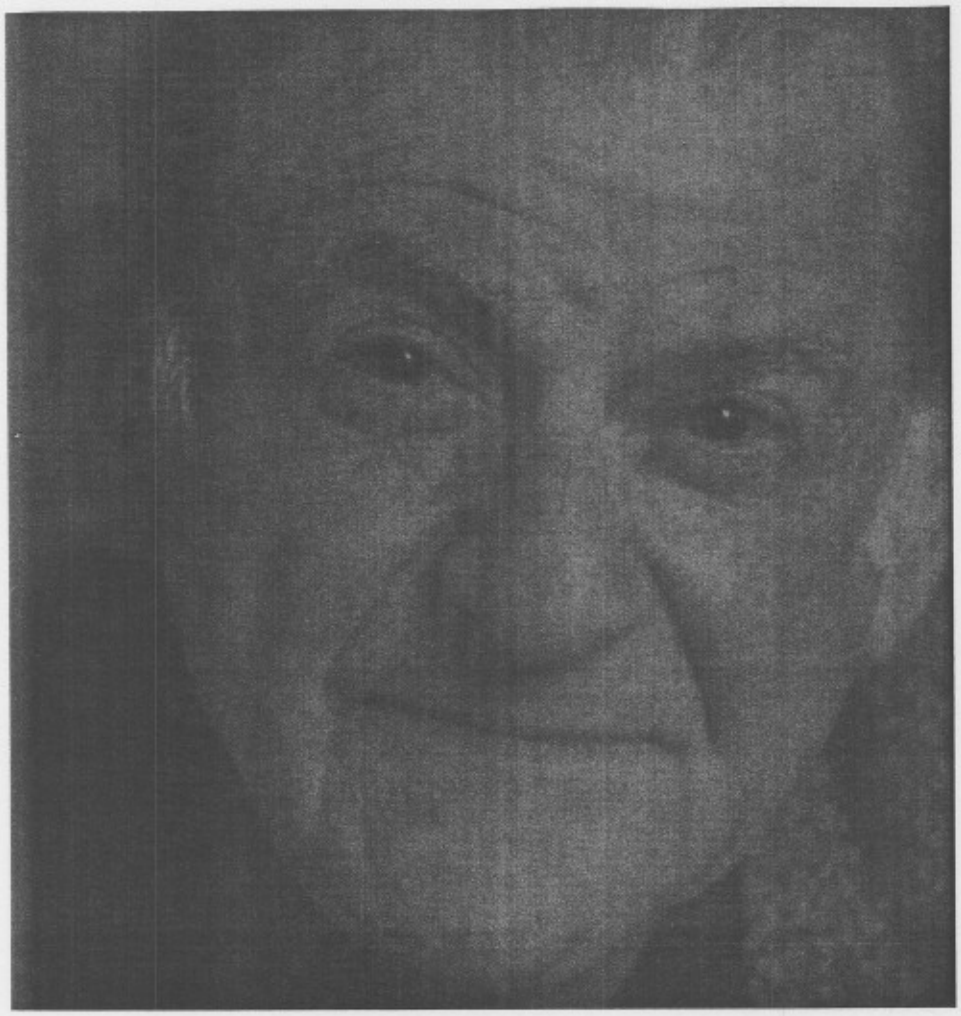
For each procedure, Oral Health America asked states whether or not the procedure required pre-authorization by the Medicaid program, and the rate at which providers were reimbursed by the Medicaid program for the procedure. Reimbursement rates were then compared to marketplace fees for dental procedures. Across the board, Medicaid reimbursement rates are abysmally low, resulting in low provider participation: most dentists do not treat Medicaid patients, a population that often includes those most in need of care. Fees that disallow any profit stifle the creation of an oral health infrastructure for vulnerable populations.

The following chart shows the 10th, 25th, and 50th percentiles of national customary procedure fees as reported by the American Dental Association (ADA). The Centers for Medicaid and Medicare Services (CMS) indicates that reimbursement rates that fall below the 50th percentile of providers' fees in the marketplace are inadequate to enlist sufficient providers.[10] The ADA recommends reimbursements at the 75th percentile.

The 50th percentile describes the middle fee reported by dentists nationwide. Half of reported fees exceed that value and half of reported fees fall below that value. Oral Health America chose this as the admittedly low gauge by which to set the "A" grade.

PROCEDURE	10th Percentile	25th Percentile	50th Percentile
Periodic Oral Exam	$19.00	$22.00	$26.00
Adult Prophylaxis (tooth cleaning)	$42.00	$47.00	$55.00
Periodontal Scaling and Root Planing	$92.00	$125.00	$150.00
Complete Upper Denture	$625.00	$750.00	$860.00
Single Tooth Extraction	$60.00	$73.00	$85.00

Source: American Dental Association, *2001 Survey of Dental Fees*, August 2002.



For this category, Oral Health America developed a grading scale that compares state reimbursement rates with customary market-place fees. The "C" grade was eliminated in this scale. Generally, there's very little middle ground when it comes to states establishment of reimbursement rates. A handful of states score well on one or two procedures; most earn failing grades for reimbursing providers at rates at or below the 10th percentile.

Grades for state reimbursement rates were reduced by half a grade if states required pre-authorization for the procedure, which further limits access to care.

Adult Medicaid Dental Service Reimbursement Rates Grading Scale

A	The state Medicaid program reimburses at or above the 50th percentile of market-based fees for the procedure.
B	The state Medicaid program reimburses between the 25th and 50th percentiles of market-based fees for the procedure.
D	The state Medicaid program reimburses at rates from the 10th to the 25th percentiles of market-based fees for the procedure.
F	The state Medicaid program does not provide coverage for the procedure, or reimburses at rates below the 10th percentile of market-based fees.

Source: Oral Health America survey of state dental Medicaid contacts and state Medicaid web sites, August 2003.

Uninsured Americans with severe oral disease often end up in hospital emergency rooms, where the problem is addressed through painkillers and/or tooth extractions, both of which are only a temporary fix, wasting millions of taxpayer dollars annually.

There are significant structural problems in our oral health care system, and the problems are getting worse due to demographic trends, workforce trends, public health infrastructure inadequacies, and the increasing number of children, adults, elderly and special populations not covered by Medicare or Medicaid.

Final Grades

State	Older Adult Private Dental Coverage	Level of Adult Dental Medicaid Coverage	ADULT MEDICAID SERVICE REIMBURSEMENT RATES					Service Reimbursement Grade	Adult Dental Medicaid Final	Older Adult Dental Coverage Final
			Periodic Oral Exam	Prophylaxis-Adult	Periodontal Scaling & Root Planing	Upper Dentures	Single Tooth Extraction			
ALABAMA	D	F			NO BENEFITS			F	F	F
ALASKA	B	D	F	F	F	F	B-	F	D-	D+
ARIZONA	B	D	B-	B-	D-	D-	D-	D+	D	C-
ARKANSAS	F	D	F	F	F	F	I	F	F	F
CALIFORNIA	A	A	F	F	F	F	F	F	C	C+
COLORADO	C	C	F	F	D-	F	F	F	D	D+
CONNECTICUT	D	C	F	F	F	F	F	F	D	D
DELAWARE	I	F			NO BENEFITS			F	F	F
DISTRICT OF COLUMBIA	I	F			NO BENEFITS			F	F	F
FLORIDA	C	D	F	F	F	F	F	F	F	D
GEORGIA	C	D	F	F	F	F	D	F	F	D
HAWAII	A	D	A-	F	I	F	F	D-	D-	C-
IDAHO	F	C	F	F	F	F	F	F	D	F
ILLINOIS	D	C	F	F	F	F	F	F	D	D
INDIANA	D	B	D	B	B	F	D	D+	C	C-
IOWA	F	C	F	F	D-	F	F	F	D	D-
KANSAS	C	D	D	F	F	F	F	F	F	D
KENTUCKY	F	C	A	F	F	F	F	D-	D+	D-
LOUISIANA	F	D	D-	F	F	F	F	F	F	F
MAINE	F	D	F	F	F	F	D	F	F	F
MARYLAND	B	F			NO BENEFITS			F	F	D
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MICHIGAN	B	D	F	F	F	F	F	F	F	D+
MINNESOTA	I	C	F	F	I	F	F	F	D	D
MISSISSIPPI	F	D	F	F	F	I	F	F	F	F
MISSOURI	D	C	B	F	I	F	F	D-	D+	D
MONTANA	F	C	F	F	D	F	F	F	D	D-
NEBRASKA	F	B	F	F	D-	F	F	F	D+	D
NEVADA	B	D	F	F	F	F	D	F	F	D+
NEW HAMPSHIRE	D	D	F	B	F	F	D-	D-	D-	D-
NEW JERSEY	C	C	F	F	F	F	F	F	D	D+
NEW MEXICO	C	A	D	F	D-	D-	F	F	C	C
NEW YORK	C	A	A	A	F	F	F	D+	B-	C+
NORTH CAROLINA	I	C	A	F	F	F	F	D-	D+	D+
NORTH DAKOTA	F	A	F	F	D-	F	F	F	C	D+
OHIO	D	B	F	F	F	F	F	F	D+	D+
OKLAHOMA	F	D	A	F	F	F	F	D-	D-	F
OREGON	D	C	B	F	F	F	I	D-	D+	D
PENNSYLVANIA	D	B	D	F	F	F	F	F	D+	D+
RHODE ISLAND	D	C	F	F	F	F	F	F	D	D
SOUTH CAROLINA	I	D	F	F	F	F	D	F	F	F
SOUTH DAKOTA	F	C	D	F	F	F	F	F	D	D-
TENNESSEE	F	D	B	D	B-	D-	D	C-	D+	D-
TEXAS	D	F			NO BENEFITS			F	F	F
UTAH	D	D	F	F	F	F	F	F	F	F
VERMONT	D	C	F	F	F	F	B	F	D	D
VIRGINIA	D	F			NO BENEFITS			F	F	F
WASHINGTON	D	A	B	F	F	F	F	F	C	C-
WEST VIRGINIA	F	D	F	F	F	F	I	F	F	F
WISCONSIN	F	B	F	F	F	F	F	F	D+	D
WYOMING	D	D	F	F	F	F	D	F	F	D-
UNITED STATES	**D**	**D+**						**F**	**D-**	**D**

Acknowledgements

Oral Health America would like to thank Gregory Folse, DDS, and Special Care Dentistry, an organization devoted to promoting the oral health and well being of people with special needs, for providing invaluable assistance with this report. We appreciate their partnership in this project to raise awareness of the unmet oral health care needs of special care populations. Thanks also to Don Schneider, DDS, MPH; the state dental Medicaid contacts; and the State and Territorial Dental Directors.

The Campaign for Oral Health Parity is made possible with the generous support and commitment of the W.K. Kellogg Foundation. Oral Health America is the nation's premier independent organization devoted to oral health.

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